Received
7/24/2020
Pacific Workers'

**

CORVEL

# Non-Certification Recommendation

| | | | |
|---|---|---|---|
| **CLAIM #:** | 040519008736 | **INSURED:** | Biotelemetry, Inc. / Chubb & Son (WC) - Los Angeles, CA |
| **DOI:** | 02/15/2019 | **CARRIER/TPA:** | Chubb & Son (WC) - Los Angeles, CA / |
| **CLAIMANT:** | **Jonathan Shockley** | **ADJUSTER:** | Mario Castro |
| **CORVEL #:** | 139249073-UMO-25 | | |

**Determination Date:** 07/21/2020

**RFA Received Date:** 07/14/2020

**Provider:** Babak Jamasbi, MD

**Pre-cert #:** 139249073-UMO-25

CorVel Corporation has been asked to review the below noted treatment request for medical necessity and appropriateness. After careful review of the submitted medical information, our Physician Advisor, David Hoenig, M.D., CA #A82847, who is board certified in Pain Medicine, Neurology and Brain Injury Medicine, was unable to recommend the requested treatment. The non-certification decision was made on 07/21/2020.

| THERAPY | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Determination** | **Type of Therapy** | **Total # Visits** | **Total Visits/ Week** | **Total Weeks** | **Body Part** | **CPT** | **Effective Date** | **Termination Date** | **Facility** | **Provider** |
| Requested | Acupuncture | 12 | | | Left - Hand, Left - Lower Arm, Left - Wrist, Right - Hand, Right - Lower Arm, Right - Wrist | 97813, 97814, 97026, 97124 | | | | |
| Non-Certified | Acupuncture | 12 | | | Left - Hand, Left - Lower Arm, Left - Wrist, Right - Hand, Right - Lower Arm, Right - Wrist | 97813, 97814, 97026, 97124 | 7/21/20 | 7/21/21 | | |

Guidelines used in the determination process:

ACOEM, Chronic Pain, effective May 15, 2017

Received
7/24/2020
Pacific Workers'

**

CORVEL

The clinical reasons regarding medical necessity, or lack of medical necessity, for non-certification are attached.

Please note the utilization review process is mandatory and has been done in accordance with California Labor Code §4610. The Medical Treatment Utilization Schedule has been utilized in the determination process, as required in Title 8, California Code of Regulation 9792.6.1.

Any dispute shall be resolved in accordance with the independent medical review provisions of Labor Code section 4610.5 and 4610.6. An objection to the utilization review decision must be communicated by the injured worker, the injured workers representative, or the injured workers attorney on behalf of the injured worker on the enclosed Application for Independent Medical Review, DWC Form IMR, within 30-calendar days of receipt of this decision.

You have the right to disagree with the decision affecting your claim. If you have any question about the information in this notice, please call your adjuster, Mario Castro, at (213) 612-0880. However if you are represented by an attorney, please contact your attorney instead of your adjuster.

For information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an information and assistance (I&A) officer of the state Division of Workers' Compensation. For recorded information and a list of offices, call toll-free 1-800-736-7401.

The appeals process is on a voluntary basis. Should the requesting medical provider wish to appeal the non-certification or modification decision, and/or have additional pertinent medical information which has not previously been submitted for review. You may submit a request for appeal to CorVel Corporation or the claims administrator, You may include any additional clinical information if you have any. This will be reviewed by a different reviewing physician. Requests for appeal need to be sent to CorVel Corporation or the claims administrator within ten (10) days after the receipt of the utilization review decision. A response to your appeal will be rendered within thirty (30) days after receipt of the request. Requests for appeal do not replace the objection process noted above and are voluntary.

In accordance with regulation section 9792.1(e)(5)(K), if the requesting physician wishes to speak to the reviewing physician regarding this determination, you can call (714)385-8500 to arrange an agreed upon scheduled time between the hours of 8:30a.m. to 5:30p.m. Monday through Friday (PST). Should the reviewing physician be unable to speak with you, another reviewer who is competent to evaluate the specific clinical issues involved in the medical treatment services will be made available.

Sincerely,

Ann Collier, RN
Utilization Management Department

cc: Office Copy

Mario Castro

Received
7/24/2020
Pacific Workers'

**

CORVEL

Jonathan Shockley

Farber & Co

Christian Charles Colantoni

****NOTE****
**Please attach a copy of this recommendation letter with your bill; otherwise, payment may be delayed.**

*Utilization review does not include determinations of employer liability of the work injury, or of bill review for the purpose of determining whether the medical services were accurately billed.*

Received
7/24/2020
Pacific Workers'

State of California, Division of Workers' Compensation

# APPLICATION FOR INDEPENDENT MEDICAL REVIEW

**DWC Form IMR**

**TO REQUEST INDEPENDENT MEDICAL REVIEW:**

1. **Sign and date this application and consent to obtain medical records.**
2. **Mail or fax the application and a copy of the written decision you received that denied or modified the medical treatment requested by your physician to: DWC-IMR, c/o Maximus Federal Services, Inc., P.O. Box 138009, Sacramento, CA 95813-8009 FAX # (916) 605-4270**
3. **Mail or fax a copy of the signed application to your Claims Administrator.**

| | |
|---|---|
| Type of Utilization Review: ☒ Regular ☐ Expedited | Modification after appeal ☐ |
| **Employee Name (First, MI, Last):** Jonathan Shockley | |
| Address: 1000 Sutter St. San Francisco, CA 94109 | |
| Phone Number: (415) 312-4029 | Employer: Biotelemetry, Inc. |
| Claim Number: 040519008736 | Date of Injury (MM/DD/YYYY): 02/15/2019 |
| WCIS Jurisdictional Claim Number (if assigned): 20190221152954750873 74 | EAMS Case Number (if applicable):ADJ12031731 |
| Employee Attorney (if known): Farber & Co | |
| Address: 333 Hegenberger Road #504 Oakland, CA 94621 | |
| Phone Number: | Fax Number: |
| **Requesting Physician Name (First, MI, Last):** Babak Jamasbi, MD | |
| Practice Name: PRCMG | Specialty: Pain Management |
| Address: 1335 Stanford Ave. Emeryville, CA 94608 | |
| Phone Number: (510) 647-5101 | Fax Number: (510) 847-5105 |
| **Claims Administrator Name:** Chubb & Son (WC) - Los Angeles, CA / | |
| Adjuster/Contact Name: Mario Castro | |
| Address: PO Box 30850 Los Angeles, CA 90030 90030 | |
| Phone Number: (213) 612-0880 | Fax Number: |
| **Disputed Medical Treatment (Complete below section)** | |
| Primary Diagnosis (Use ICD Code where Practical): M70.832 | |
| Date of Utilization Review Determination Letter: 07/21/2020 | |
| Is the Claims Administrator disputing liability for the requested medical treatment besides the question of medical necessity? ☐ Yes ☒ No Reason: | |
| List each specific requested medical services, goods, or items that were denied or modified in the space below. Use additional pages if the space below is insufficient. | |
| 1. 12 sessions of acupuncture for the bilateral hands, wrists, and forearms | |
| | |
| | |
| | |

**Request for Review and Consent to Obtain Medical Records**

I request an independent medical review of the above-described requested medical treatment. I certify that I have sent a copy of this application to the claims administrator named above. I allow my health care providers and claims administrator to furnish medical records and information relevant for review of the disputed treatment identified on this form to the independent medical review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical reports and any other information related to my case, excepting records regarding HIV status, unless infection with or exposure to HIV is claimed as my work injury. My permission will end one year from the date below, except as allowed by law. I can end my permission sooner if I wish.

| | |
|---|---|
| Employee Signature:  | Date: 07/30/2020 |

Received
7/24/2020
Pacific Workers'

## INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW FORM

If your workers compensation claims administrator sent you a written determination letter that denied or modified a request for medical treatment made by your treating physician, you can request, at no cost to you, an Independent Medical Review (IMR) of the medical treatment request by a physician who is not connected to your claims administrator. If the IMR is decided in your favor, your claims administrator must give you the service or treatment your physician requested.

**IF YOU DECIDE NOT TO PARTICIPATE IN THE IMR PROCESS YOU MAY LOSE YOUR RIGHT TO CHALLENGE THE DENIAL, DELAY, OR MODIFICATION OF MEDICAL TREATMENT REFERRED TO ON PAGE ONE OF THE APPLICATION FOR INDEPENDENT MEDICAL REVIEW.**

**You can request independent medical review by signing and submitting this form with a copy of the written determination letter that denied or modified the medical treatment requested by your physician. You must also send a copy of the signed application to your claims administrator.**

- The information on the form was filled in by your claims administrator. If you believe that any of the information is incorrect, submit a separate sheet that provides the correct information.
- If you wish to have your attorney, treating physician, parent, guardian, relative, or other person act on your behalf in filing this application, complete the attached authorized representative designation form and return it with your application. This person may sign the application or you and submit documents on your behalf.
- If the recommended medical treatment that was denied or modified must be provided to you immediately because you are facing an imminent and serious threat to your health and your claims administrator did not perform an expedited or rushed review on your physician's request, this application **must** be submitted with a statement from your physician, supported by medical records, that confirms your condition.
- Mail or fax the application and a copy of the utilization review decision to:

  DWC-IMR, c/o Maximus Federal Services, Inc.
  P.O. Box 138009, Sacramento, CA 95813-8009
  FAX Number: (916) 605-4270

- Your IMR application, along with a copy of the written determination letter, must be received by Maximus Federal Services, Inc. within thirty-five (35) days from the mailing date of the written determination letter informing you that the medical treatment requested by your treating physician was denied or modified.
- Send a copy of the signed application to your Claims Administrator. You do not need to include a copy of the written determination letter.

### Your Right to Provide Information

You have the right to submit either directly or through your treating physician, information to support the requested medical treatment. Such information may include:

- Your treating physician's recommendation that the requested medical treatment is medically necessary for your medical condition.
- Reasonable information and documents showing that the recommended medical treatment is or was medically necessary, including all documents or records provided by your treating physician or any additional material you believe is relevant.
- Evidence that the medical guidelines relied upon to deny or modify your physicians requested medical treatment does not apply to your condition or is scientifically incorrect.
- If the medical treatment was provided on an urgent care or emergency basis, information or justification that the requested medical treatment was medically necessary for your medical condition.

If you have any questions regarding the IMR process, you can obtain free information from a Division of Workers' Compensation (DWC) information and assistance officer or you can hear recorded information and a list of local offices by calling toll-free 1 -800-736-7401. You may also go to the DWC website at www.dwc.ca.gov.DWC Form IMR (Effective 2/2014)

Received
7/24/2020
Pacific Workers'

**Authorized Representative Designation for Independent Medical Review**
**(To accompany the Application for Independent Medical Review, DWC Form IMR)**

**Section I. To be completed by the Employee:**

| | |
|---|---|
| Employee Name (Print): | |

I wish to designate

| | |
|---|---|
| Name of Individual (Print): | |

to act on my behalf regarding my Application for Independent Medical Review. I authorize this individual to receive any notice or request in connection with my appeal, and to provide medical records or other information on my behalf. I further authorize the Division of Workers' Compensation, and the Independent Medical Review Organization designated by the Division of Workers' Compensation to review my application, to speak to this individual on my behalf regarding my Application for Independent Medical Review. I understand that I have the right to designate anyone that I wish to be my authorized representative and that I may revoke this designation at any time by notifying the Division of Workers' Compensation or the Independent Medical Review Organization designated by the Division of Workers' Compensation to review my application.

In addition to designating the above-named individual as my authorized representative, I allow my health care providers and claims administrator to furnish medical records and information relevant for review of the disputed treatment to the independent review organization designated by the Administrative Director of the Division of Workers' Compensation. These records may include medical, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case. I allow the independent review organization designated by the Administrative Director to review these records and information sent by my claims administrators and treating physicians. My permission will end one year from the date below, except as allowed by law I cart end my permission sooner if I wish.

| | | |
|---|---|---|
| Employee Signature: | | Date: |

**Section II. To be completed by the Authorized Representative designated above. Law firms, organizations, and groups may represent the Employee, but an individual must be designated to act on the Employee s behalf.**

I accept the above designation to act as the above-named Employee's authorized representative regarding their Application for Independent Medical Review. I understand that the Employee may revoke this authorization at any time and appoint another individual to be their authorized representative.

| | |
|---|---|
| Name: | |
| I am a/an: | |
| (Professional status or relationship to the Employee, e.g., attorney, relative, etc.) | |
| Address: | |

Received
7/24/2020
Pacific Workers'

| | | |
|---|---|---|
| City: | State: | Zip Code: |
| Phone Number: | Fax Number: | |
| State Bar Number (if applicable): | | |
| | | |
| Representative Signature: | | Date: |

Received
7/24/2020
Pacific Workers'

NMR
Network Medical Review Co. Ltd.
An ExamWorks Company

**FILE TYPE:** Prospective
**REFERRED BY:** Ann Collier
**NAME:** Jonathan Shockley
**CASE #:** 040519008736
**EMPLOYER:** Biotelemetry, Inc.
**DOI:** 2/15/2019
**REVIEW TYPE:** Prospective
**NMR #:** 365224
**STATE JURISDICTION:** CA
**DATE:** 7/21/2020

TELECONFERENCE #1:
1) AP NAME: Babak Jamasbi MD
2) (510) 647-5101
3) DATE: 7/20/2020
4) TIME: 2:50 PM PDT
5) PERSON SPOKEN WITH: Voicemail
6) POSITION OF PERSON SPOKEN WITH: Voicemail

SUMMARY OF CONVERSATION: I left a message with the patient information and return call number for the doctor to call me back regarding the patient.

TELECONFERENCE #2:
1) AP NAME: Babak Jamasbi MD
2) (510) 647-5101
3) DATE: 7/21/2020
4) TIME: 8:00 AM PDT
5) PERSON SPOKEN WITH: Voicemail
6) POSITION OF PERSON SPOKEN WITH: Voicemail

SUMMARY OF CONVERSATION: I left a message with the patient information and return call number for the doctor to call me back regarding the patient.

**MEDICAL RECORDS:**

| | | |
|---|---|---|
| PROGRESS NOTES | Pain & Rehabilitative Consultants Medical Group | 07/10/20-07/14/20 |
| UR HISTORY REPORT | | 07/17/20 +Undated |
| MISC | | 07/14/20-07/20/20 +Undated |

Received
7/24/2020
Pacific Workers'



**CLINICAL SUMMARY**: On 7/10/2020, the patient sees Jessica Aiken, PA-C. Date of reported injury is 2/15/2015. The patient has bilateral arm and hand pain. Pain is better with conservative treatment. The patient had acupuncture with up to 20% pain reduction. The patient is taking medications. On exam, there is no abnormal pathology. It is a telemedicine visit. Plan is for medication and acupuncture.

All available medical documentation was reviewed.

| **Requested Treatment:** | **Determination:** |
|---|---|
| Is 12 sessions of acupuncture for the bilateral hands, wrists, and forearms medically necessary? | Not Certified |

**IN ANSWER TO YOUR SPECIFIC QUESTIONS:**

**Is 12 sessions of acupuncture for the bilateral hands, wrists, and forearms medically necessary?**

**ASSESSMENT:** Not Certified

**EXPLANATION FOR ASSESSMENT:** Per MTUS, "Indications: Chronic persistent pain, especially torso pain. Patients should have had NSAIDs and/or acetaminophen, stretching and aerobic exercise instituted and have insufficient results. Acupuncture may be considered as a treatment for chronic persistent pain as a limited course during which time there are clear objective and functional goals to be achieved. Consideration is for time-limited use in patients with chronic persistent pain without underlying serious pathology as an adjunct to a conditioning program that has both graded aerobic exercise and strengthening exercises." Based on the documentation provided, the ACOEM, Chronic Pain, effective May 15, 2017, is not satisfied. In particular, there is no documentation of significant functional improvement with prior acupuncture. Therefore, this request is not certified.

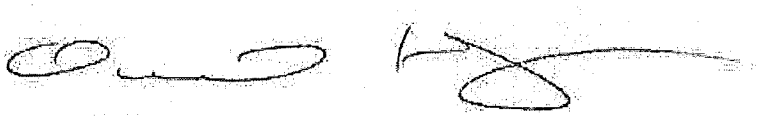
**REFERENCES UTILIZED:**

ACOEM, Chronic Pain, effective May 15, 2017
Acupuncture for Chronic Persistent Pain
Recommended.
Acupuncture is recommended to treat chronic persistent pain. (See other guidelines for specific disorders, especially for low back pain.)
Strength of Evidence Recommended, Insufficient Evidence (I)
Level of Confidence Low
Indications: Chronic persistent pain, especially torso pain. Patients should have had NSAIDs and/or acetaminophen, stretching and aerobic exercise instituted and have insufficient results. Acupuncture may be considered as a treatment for chronic persistent pain as a limited course during which time there are clear objective and functional goals to be achieved. Consideration is for time-limited use in patients with chronic persistent pain without underlying serious pathology as an adjunct to a conditioning program that has both graded aerobic exercise and strengthening exercises. Acupuncture is only recommended to assist in increasing functional activity levels more rapidly and the primary attention should remain on the conditioning program. In those not involved in a conditioning program, or who are non-compliant with graded increases in activity levels, this intervention is not recommended.
Benefits: Potential to improve pain control and advance functional exercises and conditioning.

Harms: Negligible in experienced hands. Pneumothoraces have occurred and puncture of other internal organs has occurred.
Frequency/Dose/Duration: Evidence does not support specific Chinese meridian approaches, as needling the affected area appears sufficient. Patterns used in quality studies ranging from weekly for a month to 20 appointments over 6 months. However, the norm is generally no more than 8 to 12 sessions. An initial trial of 5 to 6 appointments is recommended in combination with a conditioning program of aerobic and strengthening exercises. Future appointments should be tied to improvements in objective measures and would justify an additional 6 sessions, for a total of 12 sessions.
Indications for Discontinuation: Lack of improvement, lack of compliance with exercises, lack of incremental functional gain at the end of a treatment course, intolerance.

**Conflict of Interest Attestation:**
I certify that I do not accept compensation for review activities that is dependent in any way on the specific outcome of the case. To the best of my knowledge, I was not involved with the specific episode of care prior to referral of the case for review. I do not have a material professional, familial, or financial conflict of interest (financial conflict of interest is defined as ownership interest of greater than 5%) regarding any of the following: the referring entity; the insurance issuer or group health plan that is the subject of the review the covered person whose treatment is the subject of the review and the covered person's authorized representative, if applicable; any officer, director or management employee of the insurance issuer that is the subject of the review; any group health plan administrator, plan fiduciary, or plan employee; the health care provider, the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the review; the facility at which the recommended health care service or treatment would be provided; or the developer or manufacturer of the principle drug, device, procedure or other therapy being recommended for the covered person whose treatment is the subject of the review.

This attestation certifies that the peer reviewer named below has the appropriate scope of licensure or certification that typically manages the medical condition, procedure, treatment, or issue under review and has current, relevant experience and/or knowledge to render a determination for the case under review.



David Hoenig, M.D.
Board Certified in Neurology
Board Certified in Pain Medicine
Board Certified in Brain Injury Medicine
Licensed in State of CA #A82847

***NMR Conflict of Interest Attestation:***

*NMR attests to the fact that there is no conflict of interest with this review for referring entity, benefit plan, enrollee/consumer, attending provider, facility, drug, device or procedure. NMR attests that its compensation is not dependent on the specific outcome of this review or has had any involvement with this case prior to this referral.*

Received
7/24/2020
Pacific Workers'

CORVEL

## ELECTRONIC PROOF OF SERVICE

I am a citizen of the United States and a resident of the County of Washington; I am employed by CorVel Corporation, am over the age of eighteen years and not a party to the within entitled action; my business address is 111 SW 5th Avenue, Suite 200, Portland, Oregon, 97204.

I am readily familiar with CorVel's practice for electronic service of correspondence that is maintained on CorVel's electronic database.

On July 21, 2020, the within letter(s) were served on the parties in said action, by sending a true copy thereof **electronically** (facsimile) on the following parties:

Ann.Collier@chubb.com
Email: Ann.Collier@chubb.com

Babak J Jamasbi, MD
Fax: (510) 847-5105

Executed on July 21, 2020, at Portland, Multnomah County, Oregon, 97204.

I, Linda Grant, declare under penalty of perjury, under the laws of the **STATE OF OREGON,** that the foregoing is true and correct.

Signature

File: 139249073 Shockley

Received
7/24/2020
Pacific Workers'

CORVEL

# PROOF OF SERVICE BY MAIL

I am a citizen of the United States and a resident of the County of Clark; I am employed by CorVel Corporation, am over the age of eighteen years and not a party to the within entitled action. My business address is 4120 SE International Way, Suite A108, Milwaukie, OR 97222. I am readily familiar with CorVel's practice for collection and processing of correspondence maintained on CorVel's electronic database for mailing with the U. S. Postal Service. Under such practice, correspondence that is printed for mail service would be put in a sealed envelope with postage theron fully prepaid and placed for collection and mailing on the same date by depositing such with the U.S. postal service in the ordinary course of business.

On July 21, 2020, the within letter(s) were served on the parties in said action, by placing a true copy thereof enclosed in a sealed envelope, with postage thereon fully prepaid addressed as follows:

Babak J Jamasbi, MD
1335 Stanford Ave.
Emeryville
CA
94608

Christian Charles Colantoni
201 Spear Street, Ste. 1100
San Francisco
CA
94105

Farber & Co
333 Hegenberger Road #504

Oakland
CA
94621

Jonathan Shockley
1000 Sutter St.
San Francisco
CA
94109

Executed on July 21, 2020 at Milwaukie, OR 97222.

Received
7/24/2020
Pacific Workers'

CORVEL

I, Becca Guimont, declare under penalty of perjury, under the laws of the **STATE OF OREGON,** that the foregoing is true and correct.

Becca Guimont

Signature

File: 040519008736, Shockley Jonathan